General Assembly

Raised Bill No. 482

February Session, 2000

LCO No. **1957**

Referred to Committee on Labor and Public Employees

Introduced by:
(LAB)

An Act Concerning The Regulation Of Practitioner Joint Negotiations With Health Benefit Plans.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) The General Assembly finds that joint negotiation by competing practitioners of the healing arts and dentists of certain terms and conditions of contracts with health plans will result in procompetitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike by physicians. Although the General Assembly finds that joint negotiations over fees and other terms may in some circumstances yield anticompetitive effects it also recognizes that there are instances in which health plans dominate the market to such a degree that fair negotiations between physicians and the plan are unobtainable absent any joint actions on behalf of practitioners. In these instances, health plans have the ability to virtually dictate the terms of the contracts they offer practitioners. Consequently, the General Assembly finds it appropriate and necessary to authorize joint negotiations on fees and other issues where it determines that such imbalances exist.

Sec. 2. (NEW) As used in this act:

(1) "Health benefit plan" means a plan subject to regulation by the Insurance Department;

(2) "Practitioner" means a practitioner of the healing arts, as defined in section 20-1 of the general statutes, dentist licensed under the provisions of chapter 379 of the general statutes and psychologist licensed under the provisions of chapter 383 of the general statutes; and

(3) "Practitioners' representative" means a third party, including a member of the practitioners who will engage in joint negotiations, who is authorized by practitioners to negotiate on their behalf with health benefit plans over contractual terms and conditions affecting such practitioners.

Sec. 3. (NEW) (a) This act applies only to health benefit plans that provide benefits for medical, surgical or dental expenses incurred as a result of a health condition, accident or sickness, including an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an individual or group evidence of coverage or similar coverage document that is offered by: (1) An insurance company; (2) a group hospital service corporation; (3) a fraternal benefit society; (4) a stipulated premium insurance company; (5) a reciprocal exchange; (6) a health insurance maintenance organization; (7) a multiple employer welfare agreement; or (8) an employer.

(b) This act shall not apply to:

(1) A plan that provides coverage: (A) Only for accidental death or dismemberment; (B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; (C) as a supplement to liability insurance; (D) for credit insurance; (E) only for hospital expenses; or (F) only for indemnity for hospital confinement;

(2) A Medicare supplemental policy, as defined by Section 1882(g)(1) of the Social Security Act, 42 USC 1395ss, as from time to time amended;

(3) Medical payment insurance coverage issued as part of a motor vehicle insurance policy; or

(4) A long-term care policy, including a nursing home indemnity policy, unless the Attorney General determines that the policy provides benefit coverage so comprehensive that the policy is a health plan as described by subsection (a) of this section.

Sec. 4. (NEW) Competing practitioners within the service area of a health benefit plan may meet and communicate for the purpose of jointly negotiating the following terms and conditions of contracts with a health benefit plan:

(1) Practices and procedures to assess and improve the delivery of effective, cost-effective preventive health care services, including childhood immunizations, prenatal care and mammograms and other cancer screening tests or procedures;

(2) Practices and procedures to encourage early detection and effective, cost-effective management of diseases and illnesses in children;

(3) Practices and procedures to assess and improve the delivery of women's medical and health care, including menopause and osteoporosis;

(4) Clinical criteria for effective cost-efficient disease management programs, including diabetes, asthma and cardiovascular disease;

(5) Practices and procedures to encourage and promote patient education and treatment compliance, including parental involvement with their children's health care;

(6) Practices and procedures to identify, correct and prevent potentially fraudulent activities;

(7) Practices and procedures for effective, cost-effective use of outpatient surgery;

(8) Clinical practice guidelines and coverage criteria;

(9) Administrative procedures, including methods and timing of practitioner payment for services;

(10) Dispute resolution procedures relating to disputes between health benefit plans and practitioners;

(11) Patient referral procedures;

(12) Formulation and application of practitioner reimbursement methodology;

(13) Quality assurance programs;

(14) Health service utilization procedures;

(15) Health practitioner selection and termination criteria; and

(16) The inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question, provided such restriction does not limit practitioner rights to jointly petition the government for a change in such regulation.

Sec. 5. (NEW) Except as provided in section 6 of this act, competing practitioners shall not meet and communicate for the purpose of jointly negotiating the following terms and conditions of contracts with health benefit plans:

(1) The fees or prices for services, including those arrived at by applying any reimbursement methodology procedures;

(2) The conversion factors in a resource-based relative value scale reimbursement methodology or similar methodologies;

(3) The amount of any discount on the fee or price of services to be rendered by practitioners; and

(4) The dollar amount of capitation or fixed payment for health services rendered by practitioners to health benefit plan enrollees.

Sec. 6. (NEW) (a) Competing practitioners within the service area of a health benefit plan may jointly negotiate the terms and conditions specified in section 5 of this act where the plan has substantial market power and those terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care. The Attorney General shall determine what constitutes substantial market power.

(b) The Insurance Department shall have the authority to collect and investigate information necessary to determine, on an annual basis: (1) The average number of covered lives per month per county by every health care entity in the state; and (2) the annual impact, if any, of this act on average practitioner fees in this state.

(c) Subsection (a) of this section does not apply to: (1) A Medicaid managed care plan; or (2) a child health plan designed under Section 2101, of the Social Security Act, 42 USC 1397aa, as from time to time amended.

Sec. 7. (NEW) Competing health care practitioners' exercise of joint negotiations rights granted by sections 4 and 6 of this act shall conform to the following criteria:

(1) Practitioners may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan;

(2) Practitioners may communicate with the third party who is

authorized to negotiate on their behalf with health benefit plans over such contractual terms and conditions;

(3) The third party is the sole party authorized to negotiate with health benefit plans on behalf of the practitioners as a group;

(4) At the option of each practitioner, the practitioners may agree to be bound by the terms and conditions negotiated by the third party authorized to represent their interests;

(5) Health benefit plans communicating or negotiating with the practitioners' representatives shall remain free to contract with or offer different contract terms and conditions to individual competing practitioners; and

(6) The practitioners' representative shall comply with the provisions of section 8 of this act.

Sec. 8. (NEW) Any person or organization proposing to act or acting as a representative of practitioners for the purpose of exercising authority granted under this act shall comply with the following requirements:

(1) Before engaging in any joint negotiations with health benefit plans on behalf of practitioners, the representative shall furnish for the Attorney General's approval a report identifying: (A) The representative's name and business address; (B) the names and addresses of the practitioners who will be represented by the identified representative; (C) the relationship of the practitioners requesting joint representation to the total population of practitioners in the applicants' specialty within the geographic service area; (D) the plans with which the representative intends to negotiate on behalf of the identified practitioners; (E) the proposed subject matter of the negotiations or discussions with the identified plans; (F) the representative's plan of operation and procedures to ensure compliance with this section; (G) the expected impact of the negotiations on the quality of patient care;

and (H) the benefits of a contract between the identified plan and practitioners;

(2) After the parties identified in the initial filing have reached an agreement, the representative shall furnish, for the Attorney General's approval, a copy of the proposed contract and plan of action; and

(3) Not later than fourteen days after a plan decision declining negotiations, terminating negotiations or failing to respond to a request for negotiations, the representative shall report to the Attorney General that negotiations have ended. If negotiations resume within sixty days of such notification to the Attorney General, the applicant shall be permitted to renew the previously filed report without submitting a new report for approval.

Sec. 9. (NEW) (a) The Attorney General shall either approve or disapprove an initial filing, supplemental filing or a proposed contract not later than thirty days after each filing. If disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected. A representative who fails to obtain the Attorney General's approval shall be deemed to have acted outside the authority granted under this act.

(b) The Attorney General shall approve a request to enter into joint negotiations for a proposed contract if the Attorney General determines that the applicants have demonstrated that the likely benefits resulting from the joint negotiations or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiations or proposed contract. The Attorney General shall consider practitioner distribution by specialty and its effect on competition. The joint negotiations shall represent no more than thirty per cent of the physicians in a health benefit plan's defined geographic service area except in cases where, in conformance with the other provisions of this subsection, conditions support the approval of a greater or lesser percentage.

(c) An approval of the initial filing by the Attorney General shall be effective for all subsequent negotiations between the parties specified in the initial filing.

(d) If the Attorney General does not issue a written approval or rejection of an initial filing, supplemental filing or proposed contract within the thirty-day time period specified in subsection (a) of section 9 of this act, the applicant shall have the right to petition the superior court for the judicial district of Hartford for a mandamus order requiring the Attorney General to approve or disapprove the contents of the filing.

Sec. 10. (NEW) Nothing contained in this act shall be construed to enable practitioners to jointly coordinate any cessation, reduction or limitation of health care services. Practitioners may not meet and communicate for the purpose of jointly negotiating a requirement that a practitioner or group of practitioners, as a condition of the practitioners or groups of practitioners participation in a health benefit plan, must participate in all the products within the same plan. Physicians may not negotiate with the plan to exclude, limit or otherwise restrict nonphysician health care providers from participation in a health benefit plan, unless that restriction, exclusion or limitation is otherwise permitted by law. The representative of the practitioners shall advise practitioners of the provisions of this act and shall warn practitioners of the potential for legal action against practitioners who violate state and federal antitrust laws when acting outside the authority of this act.

Sec. 11. (NEW) The Insurance Commissioner, in consultation with the Attorney General, shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this act.

Sec. 12. (NEW) This act shall not be construed to prohibit practitioners from negotiating the terms and conditions of contracts as permitted by other state or federal law.

Statement of Purpose:

To allow practitioners of medicine, osteopathy, chiropractic, podiatry, natureopathy, optometry and dentistry to engage in joint negotiations with health care plans and medical care plans under the supervision of the Insurance Department and Attorney General to ensure procompetitive effects in the terms and conditions of contracts between such practitioners and plans for the benefit of patients.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]